

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03381 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 04951 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Margery A. Camper | | | | | | | | | | 2 Month 29 Day 1968 | | | | | | | | | | M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years last birthday) | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| Female | | | | | | | | | | White | | | | | | | | | | 10-11-1893 | | | | | | | | | | 74 YRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | U.S.A. | | | | | | | | | | | | | | | | | | | | Worcester | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Stockton | | | | | | | | | | Holland Nursing Home | | | | | | | | | | Housewife | | | | | | | | | | None | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | |
| Md. | | | | | | | | | | Worcester | | | | | | | | | | Stockton | | | | | | | | | | YES | | | | | | | | | | Stockton | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| William J. Payne | | | | | | | | | | Betty | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NO | | | | | | | | | | None | | | | | | | | | | Selma Taylor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION | | | | | | | | | | MINUTES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 410.0 | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | (b) HYPERTENSIVE C.V.D. | | | | | | | | | | 10 YRS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 420.1 | | | | | | | | | | (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BLADDER CANCER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4/2/65 | | | | | | | | | | RT NEPHRECTOMY | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | HOUR A.M. Month Day Year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION | | | | | | | | | | Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE, 1966, to FEB 28, 1968, that (I) (we) last saw the deceased alive on DEC 23, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Robert C. La Mar M D | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 3-1-68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | 104 Bay St Snow Hill, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | | | | | | | | | | | | | | | | Mt. Holly Cemetery | | | | | | | | | | Chancock-Accomack - Va. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L. N. For | | | | | | | | | | -Temperanceville, Va. | | | | | | | | | | MAR 11 1968 | | | | | | | | | | Charles J. Jones | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

1. The first part of the report is a general
description of the area. It is a small
area, about 100 acres in size, and is
located in the north-east corner of the
reserve. It is a very fertile area, and
is used for growing crops. The crops
are mostly wheat and barley. The area
is also used for grazing. There are
several small streams in the area, and
the water is used for irrigation. The
area is very important for the community,
as it is the main source of food.

2. The second part of the report is a
description of the land. It is a very
fertile area, and is used for growing
crops. The crops are mostly wheat and
barley. The area is also used for
grazing. There are several small streams
in the area, and the water is used for
irrigation. The area is very important
for the community, as it is the main
source of food.

3. The third part of the report is a
description of the water. It is a very
fertile area, and is used for growing
crops. The crops are mostly wheat and
barley. The area is also used for
grazing. There are several small streams
in the area, and the water is used for
irrigation. The area is very important
for the community, as it is the main
source of food.

4. The fourth part of the report is a
description of the community. It is a
very fertile area, and is used for
growing crops. The crops are mostly
wheat and barley. The area is also
used for grazing. There are several
small streams in the area, and the
water is used for irrigation. The area
is very important for the community,
as it is the main source of food.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> | |
| c. LENGTH OF STAY IN 1b <u>ALL Life</u> | | d. STREET ADDRESS <u>R.F.D # 2</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Carney, Jr.</u> Middle <u>Carney, Jr.</u> Last | | 4. DATE OF DEATH Month <u>2</u> Day <u>15</u> Year <u>1968</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-29-1906</u> |
| 9. AGE (In years last birthday) <u>41</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Pitt County N.C.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Robert Carney, Sr</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Ada Sharp</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Miss. Mary G. Carney</u> Address <u>5 Ford St. Greenville N.C.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH CAUSED BY: | | | |
| IMMEDIATE CAUSE (a) <u>428X</u> <u>Acute Myocarditis</u> | | | |
| DUE TO (b) <u>Chronic Myocarditis</u> | | | |
| DUE TO (c) <u>Acute Bronchitis</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2-20-</u> <u>1968</u> to <u>2-22-</u> <u>1968</u> that (I) (we) lost saw the deceased alive on <u>2-20-</u> <u>1968</u> , and that death occurred at <u>28:00 PM</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Clifford E. Schott</u> | | 22b. DATE SIGNED <u>2-27-68</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Clifford E. Schott, M.D.</u> | | 22d. ADDRESS <u>Berlin, Maryland 21811</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>2-29-68</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Holly Hill</u> | 23d. LOCATION (City or Town) (County) (State) <u>Greenville Pitt N.C.</u> |
| 24. FUNERAL DIRECTOR <u>South B. Polley</u> | | 25a. REC'D BY REGISTRAR <u>5 MAR 5 1968</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

MEDICAL CERTIFICATION

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25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 03383 | | 03363 | |
| 1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> | | c. LENGTH OF STAY IN 1b <u>Lifetime</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4 N BALTIMORE AVE</u> | | d. STREET ADDRESS <u>4 N. BALTO. AVE</u> | |
| 3. NAME OF DECEASED (Type or print) <u>LYKE R. CROPPER</u> | | 4. DATE OF DEATH <u>FEB. 15 1968</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAR. 23, 1893</u> |
| 9. AGE (In years lost birthday) <u>74 yrs.</u> | | IF UNDER 1 YEAR: Months <u>7</u> Days <u>4</u> Hours <u>15</u> Min. <u>1968</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Ocean City MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>THOMAS T. CROPPER</u> | | 14. MOTHER'S MAIDEN NAME <u>SALLY HASTINGS</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Mrs. JOHN BRITTINGHAM</u> | | Address <u>Ocean City MD</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PANHYPOPIETICULARISM, idiopathic</u> DUE TO (b) <u>2531</u> DUE TO (c) <u>2531</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>2531</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>JAN 1968</u> to <u>FEB 15, 1968</u> , that (I) (we) last saw the deceased alive on <u>FEB 7, 1968</u> , and that death occurred at <u>10 A</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>F.J. Townsends JR</u> | | 22b. DATE SIGNED <u>FEB 17, 68</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>F.J. TOWNSENDS JR</u> | | 22d. ADDRESS <u>Ocean City, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>2/18/1968</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u> | 23d. LOCATION (City or Town) (County) (State) <u>BERLIN WOR MD</u> |
| 24. FUNERAL DIRECTOR <u>Anna A. Burbage</u> | | 25a. REC'D BY REGISTRAR <u>FEB 21 1968</u> | |
| ADDRESS <u>Berlin Md</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u> | |

CERTIFICATE OF DEATH

03384

03364

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) <i>Norman James</i> | | | 2a. DATE OF DEATH Feb Month <i>24</i> Day <i>18</i> Year <i>68</i> | | | 2b. HOUR M | | | | |
| 3. SEX <i>Male</i> | | 4. RACE <i>Col</i> | | 5. DATE OF BIRTH <i>June 3 - 93</i> | | 6. AGE (In years last birthday) <i>74</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | |
| 7a. BIRTHPLACE (State or foreign country) <i>md</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Worcester Co</i> | | | | |
| 10. CITY OR TOWN OF DEATH <i>Whaleysville</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Labar</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>None</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>None</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md</i> | | | 13b. COUNTY <i>Worcester</i> | | | 13c. CITY OR TOWN <i>Whaleysville</i> | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER | | | 14. FATHER'S NAME <i>John A. Hule</i> | | | 15. MOTHER'S MAIDEN NAME <i>Hennie Jones</i> | | | 15. MOTHER'S MAIDEN NAME (First Middle Last) | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | | 16b. SOCIAL SECURITY NO. <i>220-019133</i> | | | 17. INFORMANT <i>Martha Jones</i> | | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral occlusion</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4201</i> (b) <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i> <i>5/10 yrs?</i> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arthritis</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1946</i> , 19, to <i>2-24</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>2-24</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>Frank Lewis M.D.</i> | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED <i>2-24-68</i> | |
| 22d. PHYSICIAN'S NAME (Type) <i>FRANK LEWIS</i> | | | | | | 22e. ADDRESS <i>Willards Maryland</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE <i>Feb 27 68</i> | | | 23c. NAME OF CEMETERY OR CREMATORY <i>Wheatley Cem</i> | | | 23d. LOCATION (City or town) (County) (State) <i>Whaleysville Worcester</i> | |
| 24. FUNERAL DIRECTOR <i>Looper M. Lewis</i> | | | | | | ADDRESS | | | 25a. REC'D BY REGISTRAR <i>MAR 1 1968</i> | |
| | | | | | | | | | 25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i> | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03385

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03365

| | | | | | | | | | | | | | |
|--|------------------|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (Type or Print) | | First GEORGE | | Middle --- | | Last MORSE | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Feb. 2, 1968 | | | | 2b. HOUR 7 P.M. | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH May 14, 1913 | | 6. AGE (In years last birthday) 54 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | 2c. DATE PRONOUNCED DEAD Feb. 2, 1968 | | 2d. HOUR 9:40 P.M. | |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Worcester Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Pocomoke City | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 803 Clarke Avenue | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Truck Driver | | | | 12b. KIND OF BUSINESS OR INDUSTRY Produce | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Worcester | | 13c. CITY OR TOWN Pocomoke | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 803 Clarke Avenue | | | | | |
| 14. FATHER'S NAME First Middle Last William Adams Morse | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Mary S. Fluharty | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) WW 2 | | 17. INFORMANT Mrs Mary B. Morse | | ADDRESS Pocomoke City, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Coronary Occlusion</u> | | | | | | | | | | | | Unknown | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> | | | | | | | | | | | | Unknown | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u> | | | | | | | | | | | | Unknown | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | | | City or Town | | County | | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Charles W. Trader | | Charles W. Trader, MD, | | 302 Market St., Pocomoke City | | Worcester Co., Maryland | | 22b. DATE SIGNED Feb. 2, 1968 | | | | | |
| EXAMINER'S NAME (Type) | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 2-5-1968 | | 23c. NAME OF CEMETERY First Baptist | | 23d. LOCATION (City or Town) (County) (State) Pocomoke City - Wor. - Md. | | | | | |
| 24. FUNERAL DIRECTOR Robert H. Watson | | ADDRESS Pocomoke City, Md. | | 25a. REC'D BY REGISTRAR DATE FEB 7 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | |

FOR STATE
HEALTH DEPT.

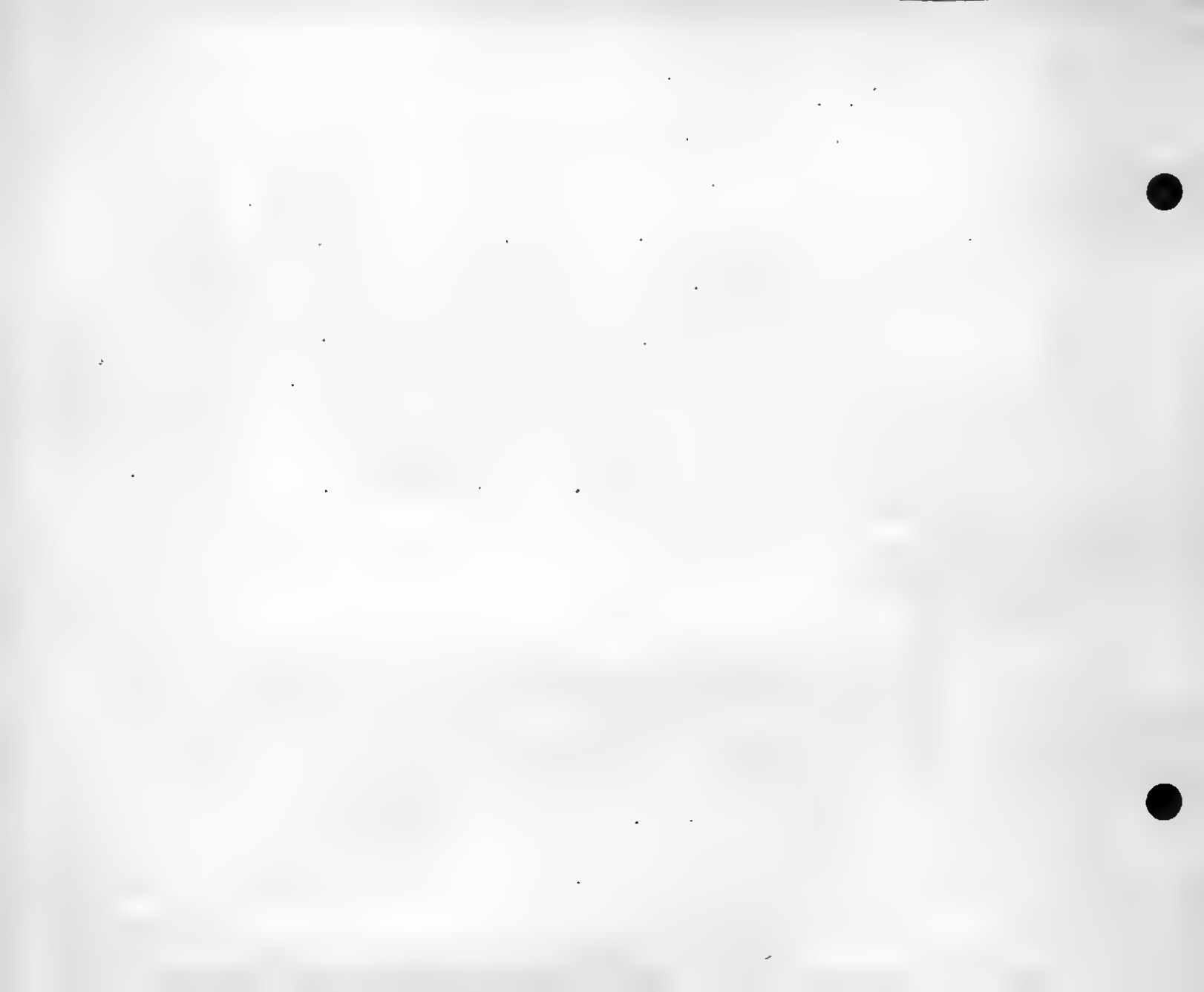
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|------------------|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (Type or Print) WALTON | | First B | | M date PARKER | | Lost | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Feb 21 19 68 | | 2b. HOUR 7:30 P.M. | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH Sept 1, 1908 | | 6. AGE (In years last birthday) 59 YRS | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | IF UNDER 24 HRS HOURS 0 MIN 0 | | 2c. DATE PRONOUNCED DEAD Month Feb Day 21 Year 68 19 9:30 A.M. | |
| 7a. BIRTHPLACE (State or foreign country) OKLAHOMA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH WORCESTER Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Ocean City | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1601 BALTIMORE AVE | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) WELDER | | | 12b. KIND OF BUSINESS OR INDUSTRY RET | | |
| 13a. U.S.A. RESIDENCE (Where deceased lived, if institution) RESIDENCE BEFORE DEATH ADMINISTRATION STATE ARKANSAS | | | | 13b. COUNTY BENTON HIWASSE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER — | |
| 14. FATHER'S NAME First WARREN | | Middle PARKER | | Last ORabelle | | 15. MOTHER'S MAIDEN NAME First ORabelle | | Middle — | | Last — | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO 45L-28-7012 | | 17. INFORMANT Nelda Brinegar (daughter) | | ADDRESS Box 422 Gentry, ARK. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 Coronary occlusion acute DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Coronary Artery disease DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH INSTANT 6 years 6 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 420 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE F. J. Townsend, Jr. | | EXAMINER'S NAME (Type) F. J. TOWNSEND, JR | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED Feb 21, 68 | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 2-25-68 | | 23c. NAME OF CEMETERY OR CREMATORY MT. PLEASANT | | 23d. LOCATION (City or Town) HIWASSE | | (County) ARK | | (State) | |
| 24. FUNERAL DIRECTOR VELDRICK FUNERAL HOME | | | | ADDRESS BERLIN, MD | | 25a. REC'D BY REGISTRAR FEB 27 1968 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form VM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03387 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 03367 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------------------------------|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Clarence | | | | | | | | | | Feb. Month 3 Day 1968 | | | | | | | | | | M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX Male | | | | | | | | | | 4. RACE Negro | | | | | | | | | | 5. DATE OF BIRTH Jan. 14, 1892 | | | | | | | | | | 6. AGE (In years last birthday) 76 YRS. | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | | | | | | | | IF UNDER 24 HRS. HOURS MIN | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Va. | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH Worcester Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Pocomoke | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 513 Laurel St. | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md. | | | | | | | | | | 13b. COUNTY Worcester Pocomoke | | | | | | | | | | 13c. CITY OR TOWN Pocomoke | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER 513 Laurel St. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last George Reed | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Laura Rogers | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes | | | | | | | | | | 16b. SOCIAL SECURITY NO. 218-20-4797 | | | | | | | | | | 17. INFORMANT Address Mary Reed 513 Laurel St. Pocomoke | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1561 IMMEDIATE CAUSE (a) Hepatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1561 (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Congestive Heart Failure + Sen. Arteriosclerosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/28, 1965, to 2/3, 1966, that (I) (we) lost the deceased alive on 2/2, 1966, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Neville A. Baron | | | | | | | | | | 22c. DATE SIGNED 2/5/66 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) NEVILLE A. BARON | | | | | | | | | | 22e. ADDRESS Pocomoke, MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | 23b. DATE 2-11-68 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Ebenezer Bapt. Cem. | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) Wardtown Northampton Va. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Samuel Sawyer | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE FEB 7 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

CERTIFICATE OF DEATH

03388

03368

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS <u>R.F.D. 2</u> | |
| 3. NAME OF DECEASED (Type or print) <u>DOROTHY RUTH SANDERSON</u> | | 4. DATE OF DEATH <u>FEB. 12 19 68</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 22, 1907</u> |
| 9. AGE (In years last birthday) <u>60</u> yrs. | | 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>CANDY STORE</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>WILMINGTON DEL</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>HIRAM HARRIS</u> | | 14. MOTHER'S MAIDEN NAME <u>ELSIE BURGESS</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>222-12-2815</u> | |
| 17. INFORMANT <u>MRS. CLARA KELLER</u> | | Address <u>BERLIN, MD</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>153.8</u> IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>Adenocarcinoma colon</u> DUE TO (c) <u>18 months</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>153.8</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>61</u> , to <u>2/12</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/12</u> 19 <u>68</u> , and that death occurred at <u>6 P</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Frank E. Gantz, Jr.</u> M.D. | | 22b. DATE SIGNED <u>2/13/68</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>FRANK E. GANTZ, JR.</u> | | 22d. ADDRESS <u>BERLIN, MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>2/14/68</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>RIVERSIDE</u> | 23d. LOCATION (City or Town) (County) (State) <u>BERLIN WICOMICO MD (R.D.)</u> |
| 24. FUNERAL DIRECTOR <u>Anna D. Burbage</u> | | 25a. REC'D BY REGISTRAR <u>FEB 16 1968</u> | |
| Address <u>Berlin Md</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

